



THE CHANGING FACE OF HEALTHCARE LAW: FROM HOLLYWOOD TO REALITY AND BEYOND

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MANAGED CARE 1A AND 1B

1A - Regulatory and Contractual Structure

1B - Compensation Methods



Regulatory Structure

Knox-Keene Health Care Service Plan Act of 1975

Health & Safety Code Sections 1340 et seq.

Department of Managed Health Care (DMHC)


Contractual Structure

- Employer group or individual contracts with health plan
- Health plan contracts with medical group
- Medical group employs or contracts with doctors:
 - Primary care physicians
 - Specialty physicians
- Sometimes there are no contracts . . .



COMPENSATION METHODS

- Hospitals usually paid per diems, DRG's
- HMO Medical Groups usually paid capitation
- Contracted/PPO physicians usually paid discounted fees off schedule
- Non contracted physicians often paid "charges."
- Risk Pools



Access to Care in the HMO System

Grievance and Appeals



Grievance

- Senior - Any complaint or dispute other than one involving an organizational determination
(42 CFR 422.561)
- Commercial - Any complaint involving a delay, denial or modification of health care services
(Knox-Keene Act, Section 1368)



Grievance

- Senior - Usually associated with a potential Quality of Care Issue, a service issue or any dissatisfaction as identified by the enrollee
- Commercial - Dissatisfaction with service OR denial of service or denial of payment of service



Appeal

- Senior - Any procedures that deal with the review of adverse organizational determinations on the health care service an enrollee is entitled to receive or any amounts the enrollee must pay for a service (42 CFR 422.561)



Appeal

- Denial, in whole or part, of an authorization for service or denial of payment for a previously rendered service



Time to Remedy

- Grievance - 30 days from date of receipt by Plan
- Appeal - pre-service - 30 days from date of receipt by Plan
- Appeal - post service - 60 days from date of receipt by Plan



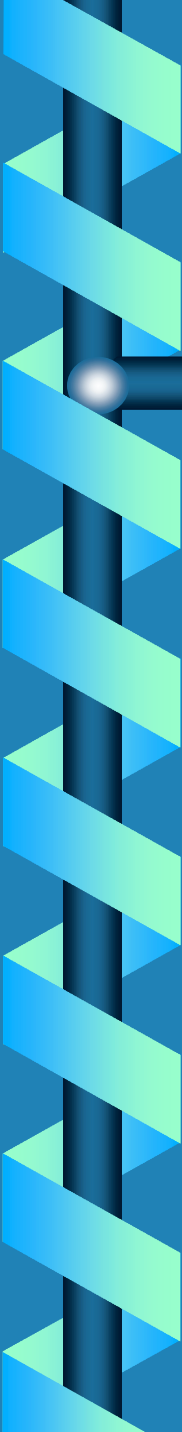
Escalation Process

- Most Plans have a two tier internal process
- Senior - CMS independent contractor
- Center for Health Dispute Resolution (CHDR)
- Commercial - DMHC HMO Help



Independent Medical Review

Department of Managed
Health Care



What is Independent Medical Review (IMR)?

- Provides patients with the right to an external, independent review of their HMO's decisions.
- Reviews are conducted by organizations who have physician experts in all specialty areas.
- Review decisions are binding on the HMO.

Actual IMR Cases

The following Health plan denials were overturned through the IMR process:

- 31 y/o male disputing denial of in-plan request for surgical procedures for Obstructive Sleep Apnea.
- 4 y/o male with Autism disputing denial of speech and behavioral therapy.
- 45 y/o female disputing denial of gastric bypass surgery for morbid obesity and diabetes.



IMR - What Cases Are Eligible?

- Denial of care based upon determination that it is “experimental or investigational”
- Denial of care based upon the determination it is “not medically necessary”
- Denial of reimbursement for emergency or urgent services as “not medically necessary”



E/I – What Qualifies?

- The patient must have a “life-threatening or seriously debilitating” condition
- The health plan has decided to delay, deny or modify a request for a drug, device, procedure, or other therapy
- The recommended drug, device, procedure or therapy would otherwise be a covered benefit – except for the determination that it is experimental or investigational

What Qualifies for a “Medical Necessity” IMR?

- An enrollee may apply for an IMR when:
 - The health plan or one of its contracting providers has:
 - denied, delayed, or modified (in whole or in part) a health care service
 - determined that the service is not medically necessary



What Qualifies for a Medical Necessity IMR?

- An enrollee may apply for an IMR when:
 - The enrollee's provider (contracted with the health plan or not) has recommended a health care service as medically necessary, or
 - The enrollee has received urgent care or emergency services that a provider determined were medically necessary, or



What Qualifies for a Medical Necessity IMR?

- An enrollee may apply for an IMR when:
 - The enrollee (without a physician recommendation) has been seen by a contracted provider for the diagnosis or treatment of the medical condition for which the s/he seeks IMR

When is A Case Eligible for a Medical Necessity IMR?

- The enrollee must participate in the plan's grievance process prior to filing for an IMR.
- The health plan has 30 days to complete the grievance process (unless the case qualifies for an expedited plan review – which is 3 days).
- The health plan is required to notify the enrollee of the option of IMR as part of the grievance determination letter.

What Does NOT Qualify for a “Medical Necessity” IMR?

- A denial based on a finding that the proposed service is not a covered benefit
- - Exception: If the benefit determination is based upon a medical conclusion (determination of a service as “cosmetic” vs. medically necessary, for example)



How Is An IMR Requested?

- The enrollee may submit an IMR application in writing or initiate the process by calling the HMO Help Center.
- The enrollee may withdraw their request for an IMR at any time during the review process.
- The health plan can reverse its original denial after a case has been submitted for an IMR.



The Review

- Once an IMR Application has been “qualified,” it is referred to an Independent Medical Review Organization (IMRO)
- The enrollee and the plan are notified upon IMRO acceptance of a case, including the IMRO name and the number and types of reviewers
 - Experimental / Investigational reviews are generally completed by a panel of three independent physicians
 - Medical Necessity reviews are generally completed by one physician



The Review

- The IMRO's review is limited to a review of medical necessity or appropriateness - not consideration of coverage decisions or other contractual issues
- The IMRO completes the review and makes its determination in writing



How to Review Prior IMR Cases

- The DMHC web site contains information regarding decisions from all IMRs conducted since January 1, 2001
- A search can be conducted by:
 - Medical Condition / Diagnosis, or
 - Treatment
- No personal information regarding patients is included.



Show Me the Money

Inside a real claims shop



Timeliness

- Senior - contracted - 60 calendar days from date of receipt
- Senior - non-contracted - 30 calendar days from date of receipt
- Commercial - 45 working days from date of receipt



Claim Type

- Review of Division of Financial Responsibility (DOFR)
- Senior - non-contracted - clean or non-clean
- Commercial -
 - Contracted - usually paid by medical group
 - Non-contracted - may be paid by either medical group or health plan, depending on terms of DOFR



Claim Development

- Gathering enough information -
authorization, medical records, test results
- to determine medical necessity
- External or other intensive review by
"specialists"

Trauma claims
NICU claims
Other high value claims



Claim Adjudication

- Payment, partial payment or denial within specified timelines
- Issuance of Remittance Advise or Evidence of Benefits
- Payment of interest on late-paid claims



PAYMENT RULES

- The Contract
- The Knox Keene Act for HMO/
managed care plans
- H & S Sec. 1371 et seq.
- AB 1455
- New Regs under 1455



ASSEMBLY BILL 1455

- Passed by the legislature in 2000
- Effective January 1, 2001
- Provided for Knox Keene prompt payment rules and adjudication of provider disputes
- Required development of regulations by July 1, 2001
- Informal draft regulations circulated in October 2001 and February 2002



AB 1455 REGULATIONS

- Regulations officially released for comment in June 2002
- Comments were due July 29, 2002
- Public hearing on July 30, 2002
- Soon to be final



Claims Payment Rules

- Defines “demonstrable and unjust payment pattern” and established authority for enforcement. If found, criminal penalties may apply.
- Precludes collection of medical records more than 3% of the time for any given provider type
- Specifies 150 day period for initial claim submission
- Specifies 5 day TAT for misdirected claims
- Acknowledge claim receipts within 2 days if submitted electronically; within 15 days if submitted on paper



Claims Payment Rules

- Plans must reimburse complete claims w/in 30 days if a health care service plan, and 45 days if an HMO.
- 15% Interest automatically included on late payments. Plus, \$10.00 penalty if interest not included
- Quarterly, plans shall, 1) verify claims payment performance of delegates, and 2) "ensure" the financial and administrative capacity of delegates to pay claims
- No contractual waivers permitted



Provider Dispute Rules

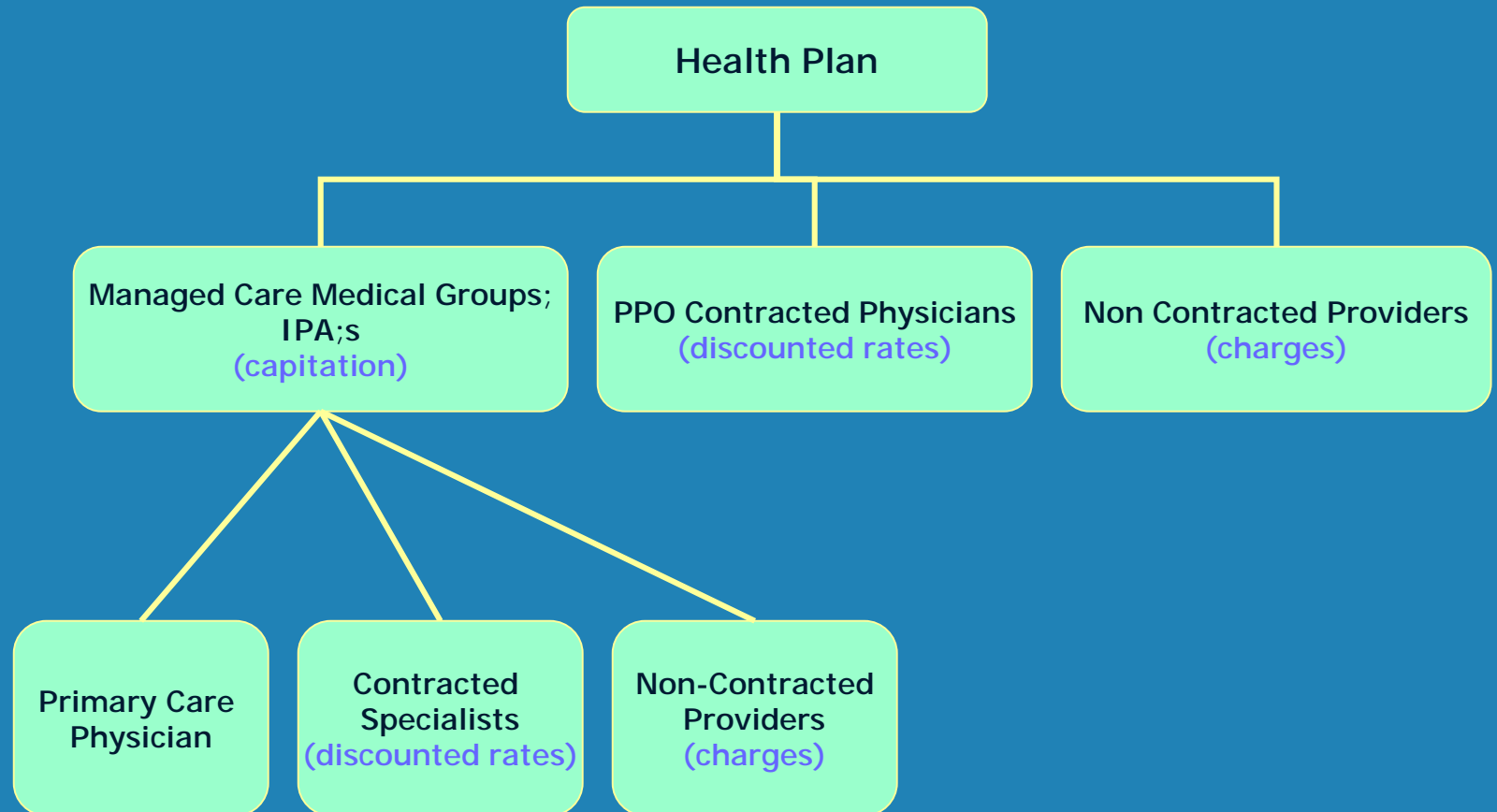
- Plans will maintain a fast, fair mechanism for provider disputes
- May delegate function
- Written description of PDR must be provided with denied, delayed, or modified claims
- Disputes must be in writing according to a specified format
- “Substantially similar” claim disputes may be bundled as one dispute
- 45 days to resolve disputes



Provider Dispute Rules

- Disputes may be submitted up to 365 days from disputed action (or inaction)
- Provider disputes processed by delegates may be appealed to Plan
- Delegates must submit quarterly reports and an annual report to the Plan regarding each provider dispute
- Plans must submit reports to DMHC annually

Managed Care Contract Structure





Horror Story: The Bankruptcy Scenario

Recent Bankruptcies of HMO:

Maxicare
Health Plan of the Redwoods
Lifeguard (conservatorship)



Bankruptcy of Provider Groups

Knox-Keene limited license:

FPA Medical Management
MedPartners Provider Network

Other Provider Groups:

San Mateo IPA
Mission IPA
KPC Medical Management



Liability of Health Plans for Contracted Provider Claims

California Medical Association v. Aetna
U.S. Healthcare (Court of Appeal,
Fourth District) 94 Cal.App.4th 151,
114 Cal.Rptr.2nd 109 (2001)

Desert Healthcare District v.
PacifiCare (Court of Appeal, Fourth
District), unpublished opinion (2001)



The Unresolved Question

What about non-contracted providers?



Medical Records

The KPC Experience



MEMBERS PAYMENT RESPONSIBILITY Cost Sharing

- Cost-sharing, which includes “co-payments,” is an important aspect of benefit structures and a means for plans to encourage enrollees’ responsible use of services.



MEMBERS PAYMENT RESPONSIBILITY

Co-Payments and Deductibles

- The Knox-Keene Act does not prohibit a plan from charging subscribers or enrollees a co-payment or a deductible for a basic health care service or from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that the co-payments, deductibles, or limitations are reported to, and held unobjectionable by the director and appropriately disclosed.



MEMBERS PAYMENT RESPONSIBILITY

Co-Payments and Deductibles

- Issue: Whether a contract is determined to be in its entirety, fair and reasonable, based upon a global review of all provisions of the contract including co-payments for non-basic health care services.



MEMBERS PAYMENT RESPONSIBILITY

Co-Payments and Deductibles

- Issue: Whether an enrollee will have access to a basic health care service as medically necessary.
 - Section 1367(e) mandates that all services be readily available and accessible to enrollees; Rule 1300.67 (f) requires that a plan provide basic health care services.
 -
 - A co-payment cannot be so high as to deter availability of covered services.



MEMBERS PAYMENT RESPONSIBILITY

Co-Payments and Deductibles

- Issue: Whether the annual co-payment maximum amount as stated denies the enrollee continued and full access to the benefit over an annual contract period; Whether an enrollee will have continuity of care in services, if a co-payment is not affordable and acts as a barrier to obtain services for the duration of an episode of care.



MEMBERS PAYMENT RESPONSIBILITY

Co-Payments and Deductibles

- Sec. 1375.1 requires a plan assume full financial risk for health care services. This is relevant when (1) a single benefit has high co-payments in comparison to the cost of delivering the benefit, (2) the aggregate of the co-payments of multiple benefits, is high in comparison to the cost of delivering the benefits, or (3) the co-payments of a single benefit, are high in comparison to the cost of delivering the service.



MEMBERS PAYMENT RESPONSIBILITY

Co-Payments and Deductibles

- Section 1342(b), 1363(a) and 1395--- Full and Fair Disclosure, Informed Choice, and Advertisements.



MEMBERS PAYMENT RESPONSIBILITY

Co-Payments and Deductibles

- Inadequate disclosure may arise from failing to clarify the foundations of co-payments, imprecisely defining terms, unbundling of services, and confusing placement/references in the EOC.



MEMBERS PAYMENT RESPONSIBILITY

Co-Payments and Deductibles

- Issue: Whether the co-payment to be charged over an annual contract period is so costly that either the enrollee is unable to make such a payment or, upon such payment, the benefit is structured so that it provides nominal or no coverage.

MEMBERS PAYMENT RESPONSIBILITY Federal Rules

- Federally qualified health maintenance organizations, which include those providing services to Medicare Plus Choice enrollees, must comply with federal requirements concerning cost-sharing. Although state requirements for cost-sharing specifically are preempted by provisions in the Balanced Budget Act, (42 U.S.C. 395w-26(b)(3)(B)(I), those federal mandates provide useful assistance in evaluating the appropriateness of co-payments.



MEMBERS PAYMENT RESPONSIBILITY Federal Rules

- The federal requirements limit co-payments to no more than 50% of the total cost of providing a single service and no more than 20% of the total cost of providing all basic health services. Additionally, in any calendar year the co-payment charges cannot be greater than 200% of the total annual premium, which the enrollee would be required to pay if the subscriber contract did not have any co-payments.



Balance Billing Prohibition

Sec. 1379(a) requires every contract with a provider to be in writing and to state that the subscriber or enrollee shall not be liable to the provider for any sums owed by the plan.

Section 1379(b) states that even if the contract does not have the balance billing prohibition, the contracting provider still cannot collect from the subscriber or enrollee.

In fact, under Section 1379(b), even if the contract hasn't been reduced to writing, the provider is bound by the prohibition.



Balance Billing Prohibition

Loop-hole No. One: What if the provider is not contracted?

Loop-hole No. Two: What if the provider has already secured payment from the subscriber or enrollee?

Loop-hole No. Three: What if the provider or collection agency bills the member and threatens collection action?



Balance Billing Prohibition - Reality TV

Hospital terminated its contracts with health plan and medical group. It advertised its non-contracted status. After HMO members were treated by the Emergency Department, the hospital sent bills to the members. Some of the bills came from its collection unit, which was given a distinct name and different location to make it appear as a collection agency.



Continuing Shift of Cost to Members

- Higher Copayments
- Tiered Benefits:

Pharmaceuticals
Hospitals



Conclusions

- Member Protections:

Grievance and Appeals system in the plans

Help Desk and IMR process at DMHC

- Provider Protections:

AB 1455 regulations will improve timely claims payments

AB 1455 regulations also tighten requirements on plan-provider claims dispute resolutions



Conclusions

- Provider Exposures:

Bankruptcies of plans and medical groups

Court decisions to date have not been favorable to providers

- Member Exposures:

Higher premiums, copayments and deductibles

Balance billing by providers